ST. MICHAEL'S
UNITY HEALTH TORONTO

6 9 0 3 4

Patient ID

Reset

Sleep Laboratory
Room 6-020, Bond Wing
30 Bond Street, Toronto, Ontario
M5B 1W8
tel: (416)864-5235
fax: (416)864-5417

Requisition for Sleep Study and Consultation

Please inform patient to bring proof of Health Insurance Coverage and St. Michael's Hospital Card if they have one.

IMPORTANT: Has a sleep study been done previously at St. Michael's Hospital or any other sleep laboratory?
☐ No ☐ Yes If yes, list dates of last 2 studies:_____

Please Note: In an effort to reduce wait times, your patient may have their sleep study performed at an affiliated private sleep laboratory nearby; however. their sleep physician will remain the same. If you do not wish to have your patient studied at an affiliated sleep laboratory, please check here: ☐

St. Michael's Hospital has adopted a new Phone Automated Reminder System (PARS) which will systematically call patients to remind them of their upcoming appointments. If your patient does not wish to be contacted by this automated method, please check here: ☐

REQUESTING PHYSICIAN

Name (please print)

Mailing Address

Telephone Number | Fax Number

Additional copy of report to be sent to

Name (please print)

Mailing Address

Telephone Number | Fax Number

CLINICAL INFORMATION RELEVANT TO TEST

Referral Request:

☐ Sleep study and consultation
☐ Sleep study only
☐ Consultation only

Reason for Referral:

☐ Obstructive sleep apnea (OSA) / snoring
☐ Insomnia
☐ Restless legs
☐ Excessive daytime sleepiness
☐ Other:

Urgent Indications:

☐ Suspected severe OSA
☐ Patient working in a safety critical occupation (e.g. bus driver, pilot, heavy machine operator, etc.)
☐ Patient has one or more of the following co-morbidities:
- cardiac or cerebrovascular disease
- refractory or uncontrolled hypertension
- severe pulmonary disease
- pulmonary hypertension
- hypercapnia
- pregnancy

☐ Pre-op screening request: Surgery date _____

Special Needs:

Is patient on oxygen? ☐ No ☐ Yes: L/m _____
☐ Night time only ☐ Day and night
Is patient on CPAP/BiPAP? ☐ No ☐ Yes: cmH2O

_____ MD
Requesting Physician Signature

Date of Request: _____

OHIP Billing Number: _____

FOR HOSPITAL USE ONLY

VISIT	DATE	TIME	INSTRUCTIONS FOR STAFF
Sleep Study			
Clinical F/U			

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